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ARKANSAS CITY PRESBYTERIAN MANOR	1711 N 4TH ST ARKANSAS CITY, KS 67005

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #76287 and #76383. A revised copy of the deficiencies was sent to the provider on 7/24/14.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility had a census of 56 residents, with 6 residents reviewed. Based on interview and record review, the facility failed to provide care for one sampled resident (#1) in a dignified manner related to dressing. Findings included: - The facility admitted resident #1 to the facility on 5/18/11, according to the admission sheet in the clinical record, with diagnoses of history of TIA (Transient ischemic attack - episode of cerebrovascular insufficiency) and dementia (progressive mental disorder characterized by failing memory, confusion). The resident's 5/22/14 annual MDS (Minimum Data Set) recorded the inability to complete a BIMS (Brief Interview for Mental Status) with severe cognitive impairments, identified the resident with short and long term memory	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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problems, severely impaired decision making skills, required extensive assistance of 2 staff for transfers and bed mobility, walking in the room/corridor did not occur, dressing and personal hygiene.

The resident's 6/5/14 care plan had the following interventions:
Please explain each procedure to me.
Am non-ambulatory and am unable to stand.
Used a wheelchair for locomotion with total assistance of 1 staff. Am totally dependent and need assistance of 1 or 2 staff with most ADL (activities of daily living) tasks. The assistance required may vary from day to day. Needed extensive assistance with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene.

Staff recorded in the 6/9/14 nursing notes at 7:20 PM, the resident pulled out the gastrostomy feeding tube. Staff notified the physician and obtained an order to transfer the resident to the hospital for reinsertion of the feeding tube. At 11:45 PM, staff recorded the resident returned to the facility from the hospital. Staff recorded the transport staff reported while the hospital staff pushed the resident into the hospital in the wheelchair, the resident slid out of the wheelchair to the floor.

On 7/8/14 at 9:28 AM, observation revealed direct care staff G and S dressed the resident in slacks and a top, prior to transferring the resident from the bed to the wheelchair with a mechanical lift.

On 6/26/14 at 11:55 AM, the resident's child stated, when the facility transferred the resident to the hospital on 6/9/14, the resident had no clothes on the resident's bottom, had a shirt on,

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and fell to the hospital floor hallway with no clothing in place below the resident's waist.

On 7/7/14 at 4:27 PM, direct care staff D stated when he/she transferred the resident to the wheelchair for transportation to the hospital, licensed staff E told the direct care staff to put an incontinent pad in the wheelchair seat, wrap a sheet around the resident, and tuck the sheet around the resident's legs. The resident had a blouse on and once staff had the resident in the wheelchair, staff pulled the incontinent pad up as best as the staff could. Staff could not tape the incontinent pad to cover the resident's bottom, so staff wrapped the sheet on top of the resident's legs and around the resident's lap to cover the resident where the blouse did not cover the resident.

On 7/7/14 at 4:59 PM, licensed staff E stated he/she told the aides to get the resident dressed so staff could transport the resident to the hospital. He/she did not look under the sheet. He/she thought the resident wore a brief.

On 7/8/14 at 2:45 PM, licensed staff Q stated residents are usually clothed when we transport a resident to the hospital. He/she stated dignity is a big concern here. Residents should not be exposed in anyway.

On 7/10/14 at 10:49 AM, licensed administrative staff B stated staff did not want to disrupt the resident and had covered the resident with a blanket for the transfer to the hospital. Staff covered the resident.

On 7/10/14 at 11:33 AM, licensed staff F stated staff need to dress residents like a normal person

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F 241	Continued From page 3 when transported to the hospital unless in an emergency situation. He/she stated he/she did not think the situation was handled appropriately. On 7/10/14 at 4 PM, administrative licensed staff L stated the facility lacked a policy to direct staff in the proper manner for dressing a resident for transport in the facility van. He/she stated would expect staff to dress the resident like a normal person. On 7/14/14 at 4:03 PM, direct care staff M stated when the resident fell in the hospital entrance, he/she was wrapped in a sheet, had slippers on his/her feet, and only had a blouse on. That is the part that really upset him/her. Staff M stated they saw the resident's naked bottom and they were embarrassed. The facility failed to provide care to this resident in a dignified manner, as the facility failed to properly dress the resident for transport to the hospital in a manner to adequately cover the resident and prevent exposure of the resident.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		

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F 280	Continued From page 4 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility reported a census of 56 residents, with a sample of 6 residents. Based on observation, interview and record review, the facility failed to review and revise the care plan following falls for 1 (#2) of the 6 residents sampled. Findings included: - The Physician Order Sheet, dated 5/18/14, documented resident #2 admitted to the facility on 6/1/12 with the following diagnosis: Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), Polyneuropathy (damage or disease affecting peripheral nerves on both sides of the body, featuring weakness, numbness, and burning pain), Macular Degeneration (progressive deterioration of the retina), Osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), Osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), Hypertension (elevated blood pressure), urinary incontinence (loss of bladder control), and senile cataract (clouding of the lens of the eye).	F 280		

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The Quarterly MDS (minimum data set), dated 4/10/14, documented the resident BIMS (brief interview of mental status) score of 05, severely impaired cognition with verbal behavioral symptoms directed toward others occurred 1-3 days. The resident requires limited to extensive assist of 1 staff for ADL's (activities of daily living), has no impairment in functional ROM (range of motion), a walker and wheelchair are used for mobility, is currently on a toileting program, and noted to be frequently incontinent of bowel and bladder. The resident had two or more non-injury falls noted.

The Care Plan, last updated 4/24/14, documented a history of falls and may be at risk for additional falls related to impaired balance, moderately impaired vision and dementia. Educated to request staff assist with ambulation, especially at night (Due to the resident's confusion, this intervention is not appropriate for the resident). Place the resident in the center of the bed during bed checks and as needed. Assist/remind to scoot to the center of the bed as needed. Wear non-skid socks or shoes. Check every 30 minutes to ensure that the resident is not ambulating independently. The resident has been assessed as being unsafe to run the control to the lift recliner; however the DPOA (durable power of attorney) would like the resident to be able to run the lift anyway, so be sure he/she can reach the control when in the chair. Winged mattress to remind where the edge is, to help from rolling out of bed. Please clip call light to resident's shirt to allow him/her to find it more easily. Staff has been educated to assist the resident when he/she is in the hallways heading to his/her room. On 5/4/14 (after a fall) therapy

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notified; CNA (certified nursing assistant) educated to pull wheelchair behind the resident during ambulation, in case he/she loses balance and needs to sit down quickly. On 5/15/14 (after a fall) therapy notified; Care Plan reviewed, continue current interventions. On 6/3/14 (after a fall) therapy notified; CNA educated that resident is not to be left unattended on toilet. On 6/23/14 (after a fall) therapy notified; DPOA to take recliner out of room, however on 7/7/14 the resident states DPOA decided to leave recliner (This means no intervention was implemented after this fall to prevent additional falls). On 6/30/14 (after a fall) therapy notified; May use stand lift for transfers at night if unsteady, Resident educated to call for help if unable to await CNA arrival after pushing the call light (Due to the resident's confusion, this intervention is not appropriate for the resident). On 7/2/14 (after a fall) therapy notified; Silent alarm initiated.
The care plan identified the resident experienced 7 falls over a 2 month period, from 5/4/14 to 7/2/14. Three of the resident's seven falls, lacked revision to include new interventions to prevent repeated falls on; 5/14/14, 6/21/14 and 6/27/14. One of the resident's falls, on 6/28/14, revealed an inappropriate intervention for the resident, as education is an ineffective intervention for a resident with severely impaired cognition.

On 7/8/14 at 7:52 AM, the resident rested in bed, on the right side at the edge of the bed (not in the center of the mattress as care planned), with the bed in low position; call light on the bedside table (not attached to shirt as care planned). A tab alarm noted at the bedside, on and functioning.

On 7/10/14 at 7:28 AM, the resident self-propelling in the wheelchair out of the dining

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room down the hall way. The resident propelled self to the sitting area near the nurse station then back down the hall to his/her room. Alarm noted mounted to the wheelchair at this time, on and functioning. The resident propelled into his/her bedroom and sat in the wheelchair next to the bed, began to stand, triggering the silent alarm, and staff entered and assisted the resident to the bed.

On 7/10/14 at 8:57 AM, the resident sat on the edge of the bed, with legs dangling off the side of the bed. The bed remained in the low position, without the walker or wheelchair noted at the bedside. While the resident sat up, the alarm failed to sound at this time.

On 7/10/14 at 9:06 AM, Direct Care Staff H reported that the resident does not always use the call light, and staff check frequently on the resident, usually every 2 hours or so, for assistance. The resident is toileted every 2 hours, but usually when staff comes in to check, he/she is already wet in the brief. Staff H reported the have never considered toileting the resident more frequently. The resident can and will follow simple cues for assistance, but will not retain what you ask him/her to do for the next time you work with him/her. Staff H reported the resident could not be educated, frequently falls, and is always trying to get to the bathroom when he/she falls.

On 7/10/14 at 11:34 AM, Licensed Nursing Staff F, reported it is the responsibility of the nurse on duty after a fall to implement an appropriate intervention at that time, and then as soon as the quality assurance nurse is in the facility, the staff then review the new intervention and determine if it is to stay or be changed. Staff F reported this

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resident cannot effectively be educated and therapy has repeatedly proved to not be effective for this resident.

On 7/10/14 at 1:26 PM, Licensed Nursing Staff I reported that the resident currently has a restorative program for maintenance of balance and gait, and also has a low bed and is on visual checks. He/she does not always use, in fact rarely uses, the call light. This resident can not retain education and would not be appropriate to offer that as an intervention. Staff I reported the resident always falls because of going to the bathroom. The resident is on a toileting program every 2 hours beginning each day at 7 AM, because that is the time he/she gets up every morning for breakfast.

On 7/10/14 at 2:46 PM, Direct Care Staff J reported the interventions used by staff to prevent falls are a silent alarm, low bed, walk with gait belt and walker, and drag the wheelchair behind the resident while walking the resident. The resident uses a push pad for a call light, the resident uses it sometimes, and not sometimes. Staff J reported the resident does not have a toileting schedule, but is a bed check every 2 hours.

On 7/10/14 at 2:56 PM, Direct Care Staff K reported for fall prevention for the resident staff use a gait belt, make sure the alarm is on and functioning and keep the bed in the lowest position. The resident uses the call light some, and also the alarm sounds often. Staff K reported the resident is to be toileted before and after meals, not every 2 hours and is also bed check every 2 hours.

On 7/10/14 at 11:11 AM, Administrative Nursing

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F 280	Continued From page 9 Staff B reported it is the responsibility of the charge nurse on duty to place an appropriate intervention on the care plan at the time of any resident fall. Staff B confirmed that it is not appropriate to have no new intervention on the care plan after a fall or to offer education to a resident who has severely impaired cognition. The facility provided policy for Falls, revised April 2013, documented: Residents will be identified for risk of falls and interventions implemented to reduce risk ...Resident's high-risk status will be documented on the Temporary and/or Overall Plan of Care reflecting appropriate interventions to minimize falls ...Review Fall Intervention Reference Sheet for fall follow-up suggested and document. The facility failed to review and revise the plan of care with new and/or appropriate interventions following falls on 5/14/14, 6/21/14, 6/27/14 and 6/28/14 to prevent repeated falls for this resident.	F 280		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 56 residents, with 6 residents reviewed. Based on observation,	F 309		

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interview, and record review, the facility failed to provide adequate treatment and services to promote healing for 2 of the 3 residents reviewed with stasis and/or venous ulcers (#1 & #6).

Resident #1 developed a venous ulcer (lesion of a vein in the lower extremity) on the right foot from an ace wrap left in place from 6/11/14 until 6/24/14, (13 days).

Findings included:

- The facility admitted resident #1 to the facility on 5/18/11, according to the admission sheet in the clinical record, with diagnoses of history of TIA (Transient ischemic attack - episode of cerebrovascular insufficiency), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dementia (progressive mental disorder characterized by failing memory, confusion).

The resident's 5/22/14 annual MDS (Minimum Data Set) recorded the inability to complete a BIMS (Brief Interview for Mental Status) with severe cognitive impairments, identified the resident with short and long term memory problems, severely impaired decision making skills, required extensive assistance of 2 staff for transfers and bed mobility, walking did not occur, dressing and personal hygiene, required extensive assistance of 1 staff, toilet use required extensive assistance of 2 staff, used a wheelchair, and with an indwelling urinary catheter.

The resident's 6/5/14 care plan had the following interventions:

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Skin - Please assist with a position change every 1-2 hours and as needed. Wears heel protectors at all times when in bed.
Intervention of 6/11/14 recorded a right ankle contusion. Keep foot elevated, keep ACE wrap applied. Use cold pack 10-20 minutes every hour while awake for 24 hours. Tylenol/Ibuprofen as ordered for pain. Non-weight bearing to the right lower extremity. Increase the Duragesic patch from 25 mcg (micrograms) to 50 mcg, every 72 hours for pain.
Intervention of 6/24/14 recorded to DC (Discontinue) the Ace wrap. Clean front of Right ankle with saf clens (cleaning solution for a wound), apply Betadine (Antiseptic solution-Helps prevent infection in cuts, scrapes and minor burns.) twice a day until healed.
Intervention of 6/30/14 recorded right lateral foot venous stasis and right Achilles (area above the heel) blister/venous stasis.

Staff recorded in the 6/9/14 nursing notes at 7:20 PM, documented the resident fell two times this day. Upon skin assessment, staff did not identify any skin concerns to the resident's feer/ankles.

Staff recorded in the 6/10/14 nursing notes at 10 AM, staff called the nurse into the east spa to look at the resident's right ankle. Staff recorded the resident's right ankle was slightly swollen on the lateral aspect (the side of the foot). The resident allowed staff to perform passive range of motion (moving of a joint through its range of motion without exertion by the resident) without signs/symptoms of pain. The resident was able to bear a little weight on the right ankle. Staff faxed the physician about the resident's right ankle.

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Staff recorded in the 6/11/14 nursing notes at 3:44 PM, the on call physician faxed no new orders in response to the 6/10/14 fax regarding the condition of the resident's right ankle.

Staff recorded in the 6/11/14 nursing notes at 5:52 PM, staff noted 2+ edema (swelling resulting from an excessive accumulation of fluid in the body tissues) to the resident's right ankle, and the resident's ankle was externally rotated (turned outward). Staff attempted passive range of motion, and the resident exhibited signs/symptoms of pain, with grimacing and became combative. Staff paged the on call physician. At 6:18 PM, the physician called the facility and ordered the resident sent to the hospital due to right ankle pain and swelling.

Staff recorded in the 6/11/14 nursing notes at 11:15 PM, the resident arrived back to the facility per the facility van. Physician orders included to keep the ace wrap applied, use cold pack for 10-20 minutes every hour while awake for the next 24 hours, follow-up with the on call physician in 1 to 2 days, and no weight bearing. Staff recorded the resident had an ace wrap in place to the right ankle at that time.

Staff recorded in the 6/13/14 nursing notes at 11:45 AM, a telephone order received from the physician to discontinue the follow-up appointment related to the emergency room visit. The x-ray was normal, and the resident had no change in condition. The telephone order included to notify the resident's primary care physician if there was any change in condition.

Review of the resident's computerized and paper clinical record lacked evidence of additional

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assessment or documentation regarding the resident's right foot and/or the ace wrap until 6/15/14.

Staff recorded in the 6/15/14 nursing notes at 1:33 PM, the resident's family member approached the nurse with concerns related to the resident's right ankle wrap and the follow-up appointment. Staff recorded the resident's ace wrap was intact to the right ankle, the resident was able to wiggle his/her toes, pedal pulse palpable (able to feel the foot's pulse), and no signs/symptoms of pain noted. At 6:30 PM, staff recorded notifying the resident's family member of the cancellation of the follow-up appointment. The resident's family member requested the staff contact the physician to ask if the staff were able to remove the ace wrap. Staff recorded the staff faxed the physician as requested.

Staff recorded in the 6/15/14 nursing notes at 2:30 PM, the resident's family member reported to the nurse the resident's right leg was hurting, and requested an MRI (Magnetic Resonance Imaging) done of the resident's entire right leg from the right hip down to the ankle and foot area as the resident's family member was he/she was unsure where the resident had pain. Staff called the physician and left a message requesting an order for an MRI.

Review of the 6/16/14 and 6/17/14 nursing notes lacked evidence of an assessment of the resident's right ankle and/or right ankle ace wrap.

Staff recorded in the 6/17/14 nursing notes at 9:07 AM, staff recorded the staff then contacted the physician and requested an increase in the dose of the Duragesic pain patch or an additional

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pain medication.

Staff recorded in the 6/17/14 nursing notes at 2:45 PM, they received a call from the physician with an order to increase the Duragesic patch from 25 mcg to 50 mcg, change every 3 days for pain control. Staff informed the doctor the resident had an x-ray previously taken only of the right ankle. Staff recorded they informed the physician of the family's request for an MRI of the right leg/hip, awaiting response from the doctor.

Staff recorded in the 6/17/14 nursing notes at 5:46 PM, received an order to obtain an x-ray of the right hip at the hospital.

Staff recorded in the 6/18/14 nursing notes at 11:07 AM, staff sent the resident to the hospital for an x-ray of the right hip, with a diagnosis of right hip pain after a fall.

Staff recorded in the 6/18/14 nursing notes at 3:16 PM, the physician called the facility and stated the resident's right hip x-ray indicated no fracture was present.

Review of the nursing notes reviewed form 6/18/14 to 6/24/14 lacked documentation of any assessment of the resident's right ankle and/or the ace wrap.

Staff recorded in the 6/24/14 nursing notes at 1:56 PM, staff called into the spa after the resident's bath and found the venous stasis area on the front of right ankle. The podiatrist was here and gave new order to clean venous stasis area to the front of the right ankle with Saf-clens (wound cleaning solution), apply skin prep (solution applied to the skin to increase skin

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integrity) twice a day until healed.

Staff recorded in the 6/24/14 nursing notes at 4:43 PM, the physician ordered to discontinue the right ankle ace wrap.

Staff recorded in a late entry for 6/24/14 6-2 shift: The charge nurse reported a clear fluid filled blistered area to the resident's right foot/ankle, with dark red/purple discolored skin which was rough when touched, podiatrist here and consulted, podiatrist examined area and ordered skin prep to area to toughen skin, stated that blister should reabsorb, and he/she stated to apply skin prep and leave the area open to air. On this date, the resident' family member reported a concern that the ankle was worse, consulted charge nurse who had already observed and treated the area today, noted blister had grown in size, and the charge nurse stated that he/she had no further concerns other than blister was larger.

Staff recorded on the 6/24/14 wound report form the following:
Front of the right ankle - venous ulcer of the front right ankle, measurements of 8.2 cm (centimeters) x 6 cm, no drainage.

Staff recorded a later entry for 6/30/14 at 11 AM, administrative licensed nurse performed head to toe skin assessment while the resident was in the bath. Staff recorded the resident with a venous stasis ulcer to the right foot/ankle the blister had ruptured (opened), skin flap intact, skin was dry and flaking, no redness, swelling, warmth noted, no sign/symptoms of pain or discomfort noted upon cleansing of the wound.

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Review of the CNA (Certified Nurse Aide) daily skin screening detail, recorded from 6/11/14 at 3:53 AM through 7/8/14 at 1:39 PM, revealed the form with the only question of, "Did you see a new skin problem?" Review of this form revealed lacked documentation of any unusual concerns and/or dressings/wraps in place on the resident's right foot.

On 7/2/14, the resident had an appointment with the wound clinic, and the physician recorded on the progress notes, the resident fell one month ago with treatment of an ankle sprain with placement of an ace wrap which was not removed for some time. The resident developed blisters which ruptured.

On 7/8/14 at 8:36 AM, observation revealed licensed staff F provided a treatment to the area on the resident's right foot. Observation revealed a small blister on the back of the resident's right foot which measured approximately 1 centimeter in diameter and an open blister area on top of the resident's right foot which measured approximately 4 cm in length by 2 cm in width.

During interview on 6/26/14 at 11:55 AM, the resident's family member stated the resident complained of pain in the right ankle and wanted to take the resident back to the doctor on 6/11/14. The doctor reported the resident had a bad contusion (bruise) to the right ankle and the doctor wrapped the ankle with an ACE wrap.

On 7/8/14 at 2:45 PM, licensed staff Q stated staff sent a fax to the doctor to get an x-ray. Staff Q remembered getting in report to leave the ace wrap on until a follow-up doctor's appointment. We should have addressed the ace wrap. Staff

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Q saw the ace wrap and never saw any concern.

On 7/8/14 at 3:06 PM, licensed administrative nursing staff C stated the charge nurse did the skin assessment weekly on all the units and documented the skin assessments in the computer. The resident's ankle was hurting and an x-ray was done. The doctor called and canceled the follow-up appointment. I do not know if anyone asked the doctor about the ace wrap. Nursing staff C stated he/she looked at the resident's right foot on 6/24/14. The podiatrist was in the facility and gave treatment orders for the area. The podiatrist stated the area was a venous area and it was not normal to leave a dressing like that in place.

On 7/10/14 at 10:49 AM, licensed administrative nursing staff B stated the facility received no response from the 6/15/14 fax sent to the doctor about discontinuing the ace wrap. There was no documentation of the ace wrap in the weekly skin assessment. I think the fax order for discontinuing the ace wrap needed clarification, and the nurses had an order to keep the ace wrap in place, so they did.

On 7/10/14 at 11:33 AM, licensed staff F stated on 6/11/14, when he/she touched the resident's foot, the resident grimaced. Licensed staff reported passing the information onto the next shift during report. This licensed staff stated the family requested an x-ray of the resident's right foot. The physician saw the resident in the emergency room and ordered not to remove the ace wrap until a follow-up appointment.

On 7/15/14 at 11:09 AM, direct care staff R stated the resident fell and had an ace wrap in place on

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the right foot. This staff member R stated he/she gave the resident a whirlpool bath and removed the resident's right foot ace wrap. This staff member R stated after removing the right foot wrap, he/she saw a huge blister on the top of the resident's right foot and notified the nurse. This staff member R stated he/she did not document anything about the wrap in the computer as he/she had told the nurse about the resident's skin condition. This staff member R stated he/she usually only told the nurse when he/she identified a new skin condition.

On 7/15/14 at 3:01 PM, physician U reported he/she would expect an ace wrap left in place no longer than 4 to 5 days. The resident continued to complain of pain in the right leg, and then we did an x-ray of the right hip which was negative. He/she stated he/she did not know how long the ace wrap remained in place to the resident's right foot.

The facility's skin integrity policy, revised on 4/13, recorded nursing staff would assess skin integrity, implement preventative measures as indicated and treat skin breakdown. The policy recorded promotion of skin integrity was a primary focus of the health care team members. A licensed nurse would complete a weekly skin screening on each resident focusing on bony prominences and document in the computer. If staff noted new alterations, this change would be recorded in the computer and the nurse should initiate treatment per guidelines. CNAs (Certified Nurse Aides) would inspect the resident's general skin condition at the time of the bath. New or unusual findings should be reported to the licensed nurse and documented in the computer. Licensed nurses should follow-up by completing a

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screening of the resident's skin condition and document the findings in the computer.

The facility failed to assess the resident's right foot for 13 days after the application of an ace wrap. The resident developed a facility acquired large right foot blister, with an increase in pain medication during this time.

- The physician order sheet, dated 6/18/14, documented resident #6 readmitted to the facility on 3/11/14 with the following diagnosis: Deep Vein Thrombosis (DVT - potentially life threatening blood clot, usually in the legs), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), fluid overload (too much fluid in the blood), and Urinary Tract Infection (UTI).

The Quarterly MDS (minimum data set), dated 5/6/14, documented the resident with BIMS (brief interview of mental status) score of 14, indicating cognitively intact. The resident required limited assist of 1 staff for activities of daily living (ADL's), has no impairment in ROM (range of motion), and used a walker and wheelchair for mobility. The resident noted with skin tears and pressure reducing device in chair and bed, with a turn and repositioning program in place.

The Care Plan, dated 5/14/14, lacked any documentation of the current stasis ulcers (a necrotic, crater like lesion of the lower leg caused by chronic venous congestion) to the resident's bilateral lower extremities.

The Admission Nursing Assessment, dated 3/11/14, documented Skin Condition: 4+ pitting

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edema to both lower legs and feet with no wounds noted.

A Faxed order from the physician (communication sheet), dated 6/19/14, documented: OK for ACE wraps (elastic type wraps to decrease swelling) toes to knees.

The Wound Treatment physician orders, dated 7/8/14, documented: Venous Ulcer Right shin cleans with saf-clens, Aquacel extra hydrofiber, ABD (thick padded dressing) pad and Kerlix (stretchy thin wrap dressing) every day and PRN (as needed) until wound is healed, cover with ACE wrap from toes to knees.

The Wound Treatment physician orders, dated 7/8/14: Venous Ulcer left lateral (outer) calf cleans with saf-clens, Aquacel extra hydrofiber, ABD pad and Kerlix every day and PRN until wound is healed, cover with ACE wrap from toes to knees.

On 7/8/14 at 9:30 AM, Licensed Nursing Staff T and Administrative Nursing Staff C entered the resident's room to provide wound dressing treatment. Staff T and C washed their hands and placed gloves on, Staff T removed the old dressing, assessed the wound drainage and discussed changing the treatment for the resident based on the amount of fluid weeping from the resident's legs. Staff C discussed changing the treatment from Aquacel foam to Aquacel hydro fiber based on the foam gelling up and not as effective. Staff T cleansed the wounds with cleanser, patted it dry with gauze and covered it with Aquacel fiber and four ABD's, and wrapped the right lower extremity with Kerlix. Both staff talked with the resident about the condition of the

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legs, the change and rationale in the treatment, and the resident was agreeable. Staff frequently asked the resident if he/she was doing ok, in pain, or needed anything. Staff then proceeded to the resident's left leg and repeated the process. The resident asked staff T if he/she was still supposed to be having ACE wraps on too, reporting to the staff that the wraps were supposed to get put on his/her legs in the morning and taken off when he/she goes to bed, but that had not been getting done by the staff. Staff replied to the resident that they were not sure, but did not think so, and would have to check the orders to clarify that for the resident. Staff T left the resident's room and returned with the current TAR (treatment administration record) and reported the resident was to have ACE wraps from the toes to below the knee every morning. The resident reported that recently he/she has not been getting them on, at least for the last 2 days they have not been on, and that he/she often goes days without them. Staff T began wrapping the left leg, using 2 ACE wraps staff found in the resident's room. Staff were unable to complete even one leg with the available wraps noting there were no other wraps in the room. Staff C then left the room to see if there were any in laundry for the resident and get some more wraps to be able to complete the treatment. Staff C returned with 4 new ACE wraps reporting that laundry had some wraps being cleaned, but were not able to tell if they belonged to this resident or not. Staff T used the new wraps and finished wrapping both legs. The staff had to re-wrap numerous times due to difficulty in placement of the wraps over the resident's edematous legs, then placed non-skid socks on the resident due to the resident's shoes being soaked from the fluid weeping from the resident's legs.

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F 309	Continued From page 22 On 7/8/14 at 10:20 AM, the resident reported he/she has been a resident here about 6 months now, and came here temporarily to get back on his/her feet after having a stroke, followed by kidney failure. The resident reported he/she needed a little extra help and to get the fluids off (swollen legs to decrease) and came here to get that done and to get some therapy. The resident's goal is to transfer and ambulate with the walker, get out of the wheelchair and regain some independence. He/she feels like the legs are getting better, however reported the staff do not know what they are doing when it comes to his/her legs. The resident reported that the treatment, wraps and ace bandages, have not been getting done for several days now. The resident just had the ACE bandages put on his/her legs, and while sitting in the wheelchair, visiting the bandages came loose and fell to the floor around the resident's ankles. The resident reported, that on the days staff does wrap his/her legs, this is typical, for the dressing to fall off. The resident reported that staff say he/she refuses treatment, but what happens is the bandages fall off because they are not put on correctly and when he/she pages for help to have them put back on, the staff get frustrated as if the resident has done something wrong and just take the ACE wraps off, instead of putting them back on. Then, the resident reported, it may be a few days until the ACE wraps are even put back on again. The resident confirmed he/she does not refuse the ACE wraps, and felt they helped. The resident had to call for the nurse to come back and re-wrap the bandages at that time. On 7/8/14, review of the TAR (treatment administration record), dated 6/15/14 to 7/14/14,	F 309		

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documented: Starting 6/20/14 ACE wrap bilateral (both) lower extremities from toes to knee every day for edema. The record was initialed daily, 6/20/14 through 7/8/14.

On 7/10/14 at 1:26 PM, Licensed Nursing Staff I confirmed the resident is supposed to have both legs wrapped with ACE bandages daily in the morning and removed at bedtime. Staff I reported that the resident refuses to have the wraps placed sometimes and at those times staff does not re-approach to try again. Staff at that time opened the TAR, dated 6/15/14 to 7/14/14 and pointed out several days where the initials of the nurse were now circled for the treatment. Staff I reported that the circles around the nurse initials mean treatment was refused. Staff I confirmed that the wraps were not placed on the resident at least one day this week that Staff I worked because it was a busy day and the staff did not feel the resident's treatment was a priority.

On 7/10/14 at 2:46 PM, Direct Care Staff J confirmed the resident should have ACE bandages every day on his/her legs. Staff J reported that the resident sometimes refuses care initially and can be a little grumpy but can always re-approach after a few minutes and he/she will allow the care at that time. Staff J confirmed the ACE wraps are not on the resident every day and does not recall if the wraps have been on the resident this week at all.

On 7/10/14 at 2:56 PM, Direct Care Staff K confirmed the resident is supposed to have both legs wrapped every day. Sometimes the resident refuses care, but when he/she does, you just re-approach in a few minutes and he/she will always allow staff to do whatever is needed. Staff

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F 309	Continued From page 24 K reports that sometimes the wraps come undone, and the staff did not recall if the wraps were on the resident each day this week and confirmed there are definitely days the ACE wraps do not get put on the resident. On 7/10/14 at 11:11 AM, Administrative Nursing Staff B reported that the resident's legs are to be wrapped daily with ACE bandages and removed at night. Staff B reported that the nursing staff report to him/her that the resident refuses the wraps occasionally, so on days the wraps were not on, staff B assumed the resident had refused them. The facility failed to provide treatment as ordered to this resident with Venous Stasis Ulcers and weeping edema fluid from the resident's bilateral lower extremities.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 56 residents, with 6 residents reviewed. Based on observation, interview, and record review, the facility failed to	F 314		

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provide the care and treatment to prevent the development of pressure ulcers to the 1 sampled resident (#1), identified at risk for the development of a pressure ulcer.

Findings included:

- The facility admitted resident #1 to the facility on 5/18/11, according to the admission sheet in the clinical record, with diagnoses of history of TIA (Transient ischemic attack - episode of cerebrovascular insufficiency), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dementia (progressive mental disorder characterized by failing memory, confusion).

The resident's 5/22/14 annual MDS (Minimum Data Set) recorded the inability to complete a BIMS (Brief Interview for Mental Status) with severe cognitive impairments, identified the resident with short and long term memory problems, severely impaired decision making skills, required extensive assistance of 2 staff for transfers and bed mobility, walking did not occur, dressing and personal hygiene, required extensive assistance of 1 staff, toilet use required extensive assistance of 2 staff, used a wheelchair, with an indwelling urinary catheter, a formal assessment instrument/tool used to determine at risk for the development of a pressure ulcer, identified at risk for the development of a pressure ulcer, currently did not have a pressure ulcer, used a pressure reducing device on the bed and chair, and on a turning/repositioning program.

The resident's 6/11/14 CAAS (Care Area

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Assessment Summary) triggered the following area:
Pressure Ulcers - Had a history of resolved pressure ulcers, but currently did not have any pressure ulcers. He/she was incontinent of bowel and wore a disposable brief at all time. The resident required extensive to total assistance with all ADL (activities of daily living) tasks. Staff to assist him/her to reposition every 1-2 hours and as needed when he/she was in bed, in the recliner, or in the wheelchair.

The resident's 6/5/14 care plan had the following interventions:
Am non-ambulatory and am unable to stand. Uses a wheelchair for locomotion with total assistance of 1 staff. Am totally dependent and need assistance of 1 or 2 with most ADL tasks. Needs extensive assistance with bed mobility and transfers. Used the mechanical lift with total assistance of 2 staff for transfers.
Please assist him/her to reposition every 1 to 2 hours and as needed.

Staff recorded the resident's Braden score as follows:
4/15/14 = 12 (a score greater than or equal to 10 indicated high risk for the development of a pressure ulcer).
5/22/14 = 13

On 7/8/14 at 9:37 AM, observation revealed direct care staff G and S transferred the resident from the resident's bed to the wheelchair. Observation revealed a pressure reducing cushion in the seat of the resident's wheelchair. At that time, direct care staff G reported the resident usually stayed up until about 12 PM or 12:30 PM. Observation at 10 AM revealed the resident pushed in the

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F 314	Continued From page 27 wheelchair by direct care staff S to the family room for an activity. Observations at 10:30 AM and at 11 AM, revealed the resident in the same position. Observation at 11:43 AM, revealed the resident in the wheelchair in the dining room. At 12:55 PM, direct care staff G entered the resident's room and verified the resident sat in the wheelchair the entire morning, had went to the family room, then to lunch, and then the resident's child took the resident outside. At 1:12 PM, observation revealed direct care staff O and G then transferred the resident from the wheelchair to the resident's bed with a mechanical lift. Observation of the resident's buttocks revealed no open areas. Staff failed to provide the resident a position change for 3 hours and 35 minutes. The facility's skin and wound treatment guidelines policy revised on 4/13, recorded if a resident is assessed at risk, reposition at least every 2 hours or more frequently when in bed and at least every hour when in a chair. The facility failed to provide the care and treatment to prevent the development of pressure ulcer for this resident identified at risk for the development of a pressure ulcer. Staff failed to provide the resident a position change for 3 hours and 35 minutes.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315		

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catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 56 residents, with 6 residents reviewed. Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services to prevent further urinary tract infections for 2 of the 3 resident reviewed for urinary incontinence and/or catheter usage, resident #1 with an indwelling urinary catheter and resident #4, with a history of frequent urinary tract infections.

Findings included:

- The facility admitted resident #1 to the facility on 5/18/11, according to the admission sheet in the clinical record, with diagnoses of history of TIA (Transient ischemic attack - episode of cerebrovascular insufficiency), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), and indwelling urinary catheter due to motor neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).

The resident's 5/22/14 annual MDS (Minimum Data Set) recorded the inability to complete a BIMS (Brief Interview for Mental Status) with severe cognitive impairments, identified the

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resident with short and long term memory problems, severely impaired decision making skills, required extensive assistance of 2 staff for transfers and bed mobility, walking did not occur, dressing and personal hygiene, required extensive assistance of 1 staff, toilet use required extensive assistance of 2 staff, used a wheelchair, and with an indwelling urinary catheter.

The resident's 6/11/14 CAAS (Care Area Assessment Summary) triggered the following area:
Indwelling Urinary Catheter - Had a Foley catheter due to the diagnosis of a neurogenic bladder. Wore a disposable incontinence briefs at all time. The resident required extensive to total assistance with all ADL (activities of daily living) tasks.

The resident's 6/5/14 care plan had the following interventions:
Catheter care every shift to prevent urinary tract infections. Change the Foley catheter monthly and as needed. The resident needed to wear a leg band at all times. Staff to monitor output and chart in the care tracker.

Staff recorded in the 6/4/14 at 1:57 AM, the resident grabbed on the resident's brief and complained of pain. Staff collected an urine analysis per standing orders. Urine results noted as abnormal, with 3+ bacteria, 9-15 white blood cells, and 0-3 red blood cells.

The resident's 6/7/14 urine culture recorded the results of greater than 100,000 escherichia coli and pseudomonas aeruginosa.

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On 6/9/14, the resident's physician ordered Septra (antiobiotic) DS (Double Strength), twice a day, for 7 days, and Ampicillin (antibiotic) 500 mg (milligrams), three times a day, for 10 days, for the treatment of the urinary tract infection. On 6/11/14, the physician discontinued the Ampicillin, due to the resident's allergy to Pencillin, and ordered Keflex 500 mg, four times a day, for 7 days, for the treatment of the urinary tract infection.

On 7/8/14 at 8:36 AM, observation revealed the resident in bed and lacked any type of anchoring device in place to the catheter tubing, and the catheter tubing under the left upper thigh of the resident. At 9:37 AM, observation revealed direct care staff G and S transferred the resident from the bed to the resident's wheelchair, and the resident's catheter lacked any type of anchoring device in place.

On 7/8/14 at 1:25 PM, observation revealed direct care staff O emptied the catheter drainage bag into a plastic graduate, and then this direct care staff wiped the emptying port tip with a pre-moistened perineal wipe. Observation revealed this direct care staff failed to place any type of barrier under the plastic graduate.

On 7/10/14 at 10:40 AM, observation revealed the resident asleep in a low bed. Observation revealed the resident's catheter tubing outside of the privacy bag and on the carpeted floor in a length of approximately 10 inches.

On 7/8/14 at 12:55 PM, direct care staff G stated the resident needed a leg strap to anchor the catheter tubing. This direct care staff stated sometimes the resident would refuse the leg

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strap and verified staff had not attempted to put the leg strap on the resident's leg during their day shift. This direct care staff added staff usually used an alcohol wipe to cleanse the catheter bag drainage port.

On 7/10/14 at 10:49 AM, licensed administrative staff B stated he/she believed the resident needed to have an anchor in place to the catheter tubing and, added, staff needed to place the resident's catheter tubing in the privacy bag to ensure the tubing remained off the floor. This licensed staff stated staff needed to use an alcohol wipe to cleanse the catheter drainage port before and after emptying the urine from the drainage bag.

On 7/10/14 at 11:33 AM, licensed staff F stated the resident needed to wear a leg strap to anchor the catheter tubing and the catheter tubing needed kept off the floor.

The Centers for Disease Control 2001 article entitled, "Engineering out the risk of Infection with Urinary Catheters" recorded contaminated external surfaces of the catheter tubing placed individuals at risk for urinary tract infections because the surface served as a direct route for bacteria to enter the bladder.

The Lippincott Manual of Nursing Practice, 8th edition, page 755, recorded, secure the indwelling catheter to the resident's thigh using tape, strap, adhesive anchor, or other securement device. Keep the tubing over the resident's leg.

The facility failed to provide appropriate treatment and services to prevent further urinary tract infections for this resident, with a recent urinary

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tract infection. The facility failed to provide an anchoring device to the resident's catheter tubing to prevent trauma to the base of the resident's bladder, failed to adequately cleanse the catheter bag's drainage port, and failed to ensure the resident's catheter tubing remained off the floor.

- The Physician Order Sheet, signed 5/18/14, documented resident #4 readmitted to the facility on 2/24/14 with the following diagnoses: UTI (urinary tract infection), end stage renal failure (a terminal disease because of irreversible damage to vital tissues or organs), chronic kidney disease stage 5 secondary to hypertension (high blood pressure), nephrosclerosis (hardening of the walls of the small arteries of the kidney) and obstructive uropathy (urine cannot drain through a ureter), and neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system).

The Quarterly MDS (minimum data set), dated 6/9/14, documented the resident with BIMS (brief interview of mental status) score of 15, cognitively intact with an Indwelling Catheter and diagnosis of Neurogenic Bladder and obstructive uropathy. The resident required extensive assist of 1 staff for ADL ' s (activities of daily living) and was administered an Antibiotic on 2 out of 7 days.

The Care Plan, last updated 4/10/14, documented: Use of an indwelling 16 FR (French) F/C (Foley Catheter) with 30 cc (cubic centimeters) bulb due to diagnosis of neurogenic bladder; Leg bag in place at all times; Catheter changed every month and PRN (as needed); Monitor for any signs or symptoms of UTI (urinary tract infection), monitor for any pain related to the

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use of the catheter, and notify physician PRN.

Review of physician orders, dated from 4/7/14 to 7/9/14, revealed the physician prescribed antibiotics five times during that time frame for UTI's for this resident, on 4/7/14; 4/21/14; 5/12/14; 5/18/14 and 7/9/14.

On 7/10/14 at 9:45 AM, Direct Care Staff G and Direct Care Staff O entered the resident's room to provide catheter care. Staff G and O provided privacy for the resident and both staff placed gloves on their hands; neither staff washed their hands or used antiseptic foam/gel prior to donning gloves on their hands. Staff P placed a gait belt around the waist of the resident and had the resident stand to the walker from the wheelchair. Staff G brought a graduated container with paper towels and peri-wipes from the bathroom and placed the container on a paper towel on the floor, then placed a paper towel over the container. Staff P removed the resident's suspenders and pants while staff G proceeded to wipe the catheter tubing from point of entry down the urinary catheter tubing twice. A leg drainage bag noted to be anchored with upper and lower straps to the resident's leg. Staff G opened the drain valve on the leg bag without cleansing the valve with alcohol wipes, and during the draining of the urine from the urine collection bag into the container, the valve observed to touch the side of the container (a break in infection control practices, increasing risk for UTI's). Staff then wiped the valve with an alcohol wipe and closed the valve. Staff G took the container to the bathroom to drain the urine into the toilet, and rinsed the graduate with tap water before storing it in the bathroom, while Staff P re-dressed and sat the resident back in the

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wheelchair. Staff G and P washed their hands and left the room.

On 7/8/14 at 12:30 PM, the resident reported he/she has a catheter and frequently gets UTI's. The resident reports the infections have happened way more often than the resident would like and reports great discomfort with the infections. The resident reports he/she gets catheter care several times per day. The resident reports that when staff change the catheter leg bag, he/she had often seen staff lay the bag directly on the floor during the changing process.

On 7/10/14 at 9:46 AM, Direct Care Staff G reported that he/she frequently does catheter care on the resident multiple times per shift. Staff G confirmed that the drainage valve should not touch anything during the draining process of urine from the bag and should always be cleaned with alcohol wipes or peri wipes. Today, staff G used an alcohol wipe to clean the drain valve only after draining, but reports often only uses peri-wipes for this task.

On 7/10/14 at 11:34 AM, Licensed Nursing Staff F reported that the nursing and direct care staff should use gloves for catheter care. Staff F confirmed the drain valve should be cleaned before and after draining it into the graduated container and that the drain valve should not touch anything.

On 7/10/14 at 2:46 PM, Direct Care Staff J reported staff provides catheter care for this resident every shift at least once, but usually 2-3 times on evening shift. Staff J reported that to drain the catheter bag, staff should use gloves and drain the urine into a graduated container.

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F 315	Continued From page 35 Staff J reported that he/she does not cleanse the drain valve with anything during the draining process and does not wash his/her hands before putting on gloves, stating, "That's why we have on gloves." On 7/10/14 at 11:05 AM, Administrative Nursing Staff B reported that catheter care is to be done once per shift at a minimum and more frequently as needed for the resident. Staff B confirmed that alcohol wipes should be used on the drain valve before and after draining urine from the bag and the valve should not make contact with anything else during that process. Staff B also confirmed that staff should also wash their hands prior to placing gloves on before the catheter care is done. The facility failed to provide appropriate treatment and services to prevent further urinary tract infections for this resident with a history of urinary tract infections.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 56 residents, with a sample of 6 residents. Based on	F 323		

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observation, interview and record review, the facility failed to ensure appropriate interventions implemented to prevent repeated falls for 1 (#2) of the 3 residents sampled reviewed for accidents.

Findings included:

- The Physician Order Sheet, dated 5/18/14, documented resident #2 admitted to the facility on 6/1/12 with the following diagnosis: Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), Polyneuropathy (damage or disease affecting peripheral nerves on both sides of the body, featuring weakness, numbness, and burning pain), Macular Degeneration (progressive deterioration of the retina), Osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), Osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), Hypertension (elevated blood pressure), urinary incontinence (loss of bladder control), and senile cataract (clouding of the lens of the eye).

The Quarterly MDS (minimum data set), dated 4/10/14, documented the resident BIMS (brief interview of mental status) score of 05, indicating severely impaired cognition with verbal behavioral symptoms directed toward others occurred 1-3 days. The resident required limited to extensive assist of 1 staff for ADL's (activities of daily living), has no impairment in functional ROM (range of motion), used a walker and wheelchair for mobility, is currently on a toileting program, and noted to be frequently incontinent of bowel and bladder. The resident had two or more non-injury falls noted.

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The Care Plan, last updated 4/24/14, documented a history of falls and at risk for additional falls related to impaired balance, moderately impaired vision and dementia. The interventions included; Educated to request staff assist with ambulation, especially at night (Due to the resident's confusion. This intervention is not appropriate for the resident). Place the resident in the center of the bed during bed checks and as needed. Assist/remind to scoot to the center of the bed as needed. Wear non-skid socks or shoes. Check every 30 minutes to ensure that the resident is not ambulating independently. The resident has been assessed as being unsafe to run the control to the lift recliner; however the DPOA (durable power of attorney) would like the resident to be able to run the lift anyway, so be sure he/she can reach the control when in the chair. Winged mattress to remind where the edge is, to help from rolling out of bed. Please clip call light to resident's shirt to allow him/her to find it more easily. Staff has been educated to assist the resident when he/she is in the hallways heading to his/her room.

The care plan additions included;
On 5/4/14 (after a fall) therapy notified; CNA (certified nursing assistant) educated to pull wheelchair behind the resident during ambulation, in case he/she loses balance and needs to sit down quickly.
On 5/15/14 (after a fall) therapy notified; Care Plan reviewed, continue current interventions.
On 6/3/14 (after a fall) therapy notified; CNA educated that resident is not to be left unattended on toilet.
On 6/23/14 (after a fall) therapy notified; DPOA to take recliner out of room, however on 7/7/14 the

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resident states DPOA decided to leave recliner (This means no intervention was implemented after this fall to prevent additional falls).
On 6/30/14 (after a fall) therapy notified; May use stand lift for transfers at night if unsteady, Resident educated to call for help if unable to await CNA arrival after pushing the call light (Due to the resident's confusion, this intervention is not appropriate for the resident).
On 7/2/14 (after a fall) therapy notified; Silent alarm initiated.
The care plan identified the resident experienced 7 falls over a 2 month period, from 5/4/14 to 7/2/14. Three of the seven falls lacked had no new interventions to prevent repeated falls on; 5/14/14, 6/21/14 and 6/27/14. One of the falls, on 6/28/14, revealed an inappropriate intervention for the resident; education is ineffective with severely impaired cognition.

On 7/8/14 at 7:52 AM, the resident rested in bed, on the right side at the edge of the bed (not in the center of the mattress as care planned), with the bed in low position; call light on bedside table (not attached to shirt as care planned). A tab alarm noted at bedside, on and functioning.

On 7/10/14 at 7:28 AM, the resident self-propelling in the wheelchair out of the dining room down the hall way. The resident propelled self to the sitting area near the nurse station then back down the hall to his/her room. Alarm noted mounted to the wheelchair at this time, on and functioning. The resident propelled into his/her bedroom and sat in the wheelchair next to the bed, began to stand, triggering the silent alarm, and staff assisted the resident to bed.

On 7/10/14 at 8:57 AM, the resident sat on the

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edge of the bed, with legs dangling off the side of the bed. The bed remained in the low position, without the walker or wheelchair noted at the bedside. The alarm failed to sound at this time.

On 7/10/14 at 9:06 AM, Direct Care Staff H reported that the resident does not always use the call light, and staff check frequently on the resident, usually every 2 hours or so, for assistance. The resident is toileted every 2 hours, but usually when staff comes in to check, he/she is already wet in the brief. Staff H reported they have never considered toileting the resident more frequently. The resident can and will follow simple cues for assistance, but will not retain what you ask him/her to do for the next time you work with him/her. Staff H reported the resident could not be educated and frequently falls, and is always trying to get to the bathroom when he/she falls.

On 7/10/14 at 11:34 AM, Licensed Nursing Staff F, reported it is the nurse on duties responsibility after a fall to put an appropriate intervention at that time, and then as soon as the quality assurance nurse is in, we review the new intervention and determine if it is to stay or be changed. Staff F reported this resident cannot effectively be educated and therapy has repeatedly proved to not be effective for this resident.

On 7/10/14 at 1:26 PM, Licensed Nursing Staff I reported that the resident currently has a restorative program for maintenance of balance and gait, and also has a low bed and is on visual checks. He/she does not always use, in fact rarely uses, the call light. This resident cannot retain education and would not be appropriate to offer that as an intervention. Staff I reports the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175309	A. BUILDING _____ B. WING _____	C 07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKANSAS CITY PRESBYTERIAN MANOR	1711 N 4TH ST ARKANSAS CITY, KS 67005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 40	F 323		

resident always falls because of going to the bathroom. The resident is on a toileting program every 2 hours beginning each day at 7 AM, because that is the time he/she gets up every morning for breakfast.

On 7/10/14 at 2:46 PM, Direct Care Staff J reported the interventions used by staff to prevent falls are a silent alarm, low bed, walk with gait belt and walker, and drag the wheelchair behind the resident while walking the resident. The resident uses a push pad for a call light, the resident uses it sometimes, and not sometimes. Staff J reports the resident does not have a toileting schedule, but is a bed check every 2 hours.

On 7/10/14 at 2:56 PM, Direct Care Staff K reported for fall prevention for the resident staff use a gait belt, make sure the alarm is on and functioning and keep the bed in the lowest position. The resident uses the call light some, and also the alarm sounds often. Staff K reported the resident is to be toileted before and after meals, not every 2 hours and is also bed check every 2 hours.

On 7/10/14 at 11:11 AM, Administrative Nursing Staff B reported it is the responsibility of the charge nurse on duty to place an appropriate intervention on the care plan at the time of any resident fall. Staff B confirmed that it is not appropriate to have no new intervention on the care plan after a fall or to offer education to a resident who has severely impaired cognition.

The facility provided policy for Falls, revised April 2013, documented: Residents will be identified for risk of falls and interventions implemented to reduce risk ...Resident's high-risk status will be

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F 323	Continued From page 41 documented on the Temporary and/or Overall Plan of Care reflecting appropriate interventions to minimize falls ...Review Fall Intervention Reference Sheet for fall follow-up suggested and document. The facility failed to implement new and/or appropriate interventions to prevent further falls for this resident following 4 of 7 falls in a 2 month time period.	F 323		